

BREAST DIAGNOSTICS DATA ENTRY TOOL

AGENCY OR SITE		CLINICIAN NAME		eCasT ID	
LAST NAME		FIRST NAME		SSN	DATE OF BIRTH
					AGE

DX MAMM / ADDITIONAL VIEWS OR FILM COMPARISON RESULT:			DATE PERFORMED:		
<input type="checkbox"/> BI-RADS 1: Negative		<input type="checkbox"/> BI-RADS 3: Probably benign		<input type="checkbox"/> BI-RADS 5: Highly suggestive of malignancy	
<input type="checkbox"/> BI-RADS 2: Benign		<input type="checkbox"/> BI-RADS 4: Suspicious abnormality			
LOCATION PERFORMED:			FUNDING: <input type="checkbox"/> WWC <input type="checkbox"/> Other		

BREAST ULTRASOUND RESULT:			DATE PERFORMED:		
<input type="checkbox"/> BI-RADS 1: Negative		<input type="checkbox"/> BI-RADS 3: Probably benign		<input type="checkbox"/> BI-RADS 5: Highly suggestive of malignancy	
<input type="checkbox"/> BI-RADS 2: Benign		<input type="checkbox"/> BI-RADS 4: Suspicious abnormality			
LOCATION PERFORMED:			FUNDING: <input type="checkbox"/> WWC <input type="checkbox"/> Other		

CLINICAL BREAST EXAM (CBE) <input type="checkbox"/> Repeat CBE <input type="checkbox"/> Clinical Correlation CBE			DATE PERFORMED:		
<input type="checkbox"/> Not Suspicious for Breast Cancer					
<input type="checkbox"/> Suspicious for Breast Cancer					
LOCATION PERFORMED:			FUNDING: <input type="checkbox"/> WWC <input type="checkbox"/> Other		

SURGICAL/MEDICAL CONSULT RESULT:			DATE PERFORMED:		
<input type="checkbox"/> No Intervention at this time, routine FUP		<input type="checkbox"/> Biopsy recommended			
<input type="checkbox"/> Short Term FUP		<input type="checkbox"/> Surgery, Tx Recommended			
LOCATION PERFORMED:			FUNDING: <input type="checkbox"/> WWC <input type="checkbox"/> Other		

BIOPSY RESULT:			DATE PERFORMED:		
Type: <input type="checkbox"/> Excisional <input type="checkbox"/> Stereotactic <input type="checkbox"/> Ultrasound guided percutaneous core <input type="checkbox"/> Ultrasound vacuum assisted					
<input type="checkbox"/> Breast cancer not diagnosed		<input type="checkbox"/> Lobular carcinoma in situ/lobular neoplasia		<input type="checkbox"/> Intraductal papilloma	
<input type="checkbox"/> Atypical Ductal Hyperplasia (ADH)		<input type="checkbox"/> Ductal carcinoma in situ		<input type="checkbox"/> Insufficient sample	
<input type="checkbox"/> Atypical Lobular Hyperplasia (ALH)		<input type="checkbox"/> Invasive Breast Carcinoma			
LOCATION PERFORMED:			FUNDING: <input type="checkbox"/> WWC <input type="checkbox"/> Other		

OTHER BIOPSY SAMPLING PROCEDURE RESULT:		
Procedure:		<input type="checkbox"/> FNA ultrasound guided
<input type="checkbox"/> Cyst Aspiration		<input type="checkbox"/> Ductogram (single)
<input type="checkbox"/> FNA by palpation		<input type="checkbox"/> Ductogram (multiple)
		<input type="checkbox"/> Other* _____ (requires preapproval for coverage)
Result:		
<input type="checkbox"/> Insufficient sample		<input type="checkbox"/> Not suspicious for breast cancer
		<input type="checkbox"/> Suspicious for breast cancer
LOCATION PERFORMED:		FUNDING: <input type="checkbox"/> WWC <input type="checkbox"/> Other

FOLLOW-UP:	
DIAGNOSTIC WORK-UP IS COMPLETE (choose one below): <input type="checkbox"/> Return for annual exam <input type="checkbox"/> Patient needs short-term follow-up in _____ months <input type="checkbox"/> Treatment needed <input type="checkbox"/> Further immediate diagnostic tests required	DIAGNOSTIC WORK-UP IS NOT COMPLETE (choose one below): <input type="checkbox"/> Lost to follow-up: Date: _____ <input type="checkbox"/> Refused: Date: _____ <input type="checkbox"/> Deceased: Date: _____

FINAL DIAGNOSIS: Required 60 days after first abnormal screening.		FINAL DIAGNOSIS DATE:	
<input type="checkbox"/> Breast cancer not diagnosed		<input type="checkbox"/> *Non invasive breast cancer	
<input type="checkbox"/> *Results require treatment!		<input type="checkbox"/> *Invasive breast cancer	
<input type="checkbox"/> *Atypical hyperplasia		<input type="checkbox"/> *Lobular carcinoma in situ (LCIS)	
<input type="checkbox"/> *Ductal carcinoma in situ (DCIS)			

TREATMENT: Required when Final Diagnostic is abnormal. To be initiated within 60 days of Final Diagnosis.		TREATMENT DATE:	
<input type="checkbox"/> Treatment pending		<input type="checkbox"/> Treatment no done (choose one below):	
<input type="checkbox"/> Treatment started: Date: _____		<input type="checkbox"/> Lost to follow-up: Date: _____	
<input type="checkbox"/> Not medically indicated, not needed		<input type="checkbox"/> Refused: Date: _____	
		<input type="checkbox"/> Deceased: Date: _____	

MEDICAID ELIGIBILITY: Required when Final Diagnostic is abnormal. To be initiated within 5 days of Final Diagnosis.	
<input type="checkbox"/> Eligible	
<input type="checkbox"/> Not eligible: Reason _____	